TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Hillcrest Baptist Medical Center

Respondent Name
Insurance Co of the State of PA

MFDR Tracking Number
M4-14-3123-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted these bills within Timely Filing via fax to the WC Carrier, Gallagher Bassett. We received a "rejection letter" with our bills returned marked "no claim on file" due to the employer did not submit a "first report of injury" as a reason for our bills being rejected/returned."

Amount in Dispute: $1,093.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill(s) made the basis of this medical fee dispute are being processed for payment by the Carrier at this time. Evidence of payment will be filed as soon as it is received."

Response Submitted by: Pappas & Suchma, PA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2013	99283 -25, 90714, 90471 (Outpatient Hospital Services)	$890.30	$325.90
December 9, 2013	99283 (Physician Services)	$203.00	$94.71

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient facility services performed in an acute care hospital.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.

4. No explanation of benefit provided by either party.

Issues

1. Was the position statement of the respondent supported?
2. What is the applicable rule that pertains to the fee guidelines for the outpatient services?
3. What is the applicable rule that pertains to the fee guidelines for the professional services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states, "The bill(s) made the basis of this medical fee dispute are being processed for payment by the Carrier at this time. Evidence of payment will be filed as soon as it is received." No evidence was found payment was made. Therefore the services in dispute will be reviewed per applicable rules and fee guidelines.
2. The services in dispute billed under 99283 -25, 90714 and 90471 are all services classified as emergency services provided in an outpatient setting of an acute care hospital. 28 Texas Administrative Code 134.403 (f) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   (2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

   The services in dispute will be calculated as follows:

   - Procedure code 99283 has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0614, which, per OPPS Addendum A, has a payment rate of $143.36. This amount multiplied by 60% yields an unadjusted labor-related amount of $86.02. This amount multiplied by the annual wage index for this facility of 0.8215 yields an adjusted labor-related amount of $70.67. The non-labor related portion is 40% of the APC rate or $57.34. The sum of the labor and non-labor related amounts is $128.01. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $128.01. This amount multiplied by 200% yields a MAR of $256.02.
   - Procedure code 90714 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 90471 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of $39.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $23.48. This amount multiplied by the annual wage index for this facility of 0.8215 yields an adjusted labor-related amount of $19.29. The non-labor related portion is 40% of the APC rate or $15.65. The sum of the labor and non-labor related amounts is $34.94. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The

total Medicare facility specific reimbursement amount for this line is $34.94. This amount multiplied by 200% yields a MAR of $69.88.

- The total allowable reimbursement for the services in dispute is $325.90. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $325.90. This amount is recommended.

3. The service in dispute billed as 99283, is for an emergency service provided by Dr. Charles B. Owen II. 28 Texas Administrative Code 134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor)."

   The services in dispute will be calculated as follows:

   - Procedure code 99283, service date December 9, 2013. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.34 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.34. The practice expense (PE) RVU of 0.32 multiplied by the PE GPCI of 0.912 is 0.29184. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.809 is 0.0809. The sum of 1.71274 is multiplied by the Division conversion factor of $55.30 for a MAR of $94.71.
   - The total allowable reimbursement for the services in dispute is $94.71. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $94.71. This amount is recommended.

4. The combined allowed for the services in dispute is $420.61. No evidence was found the Carrier made any payment. The amount due to the requestor is $420.61.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $420.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $420.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.